



PRIOR APPROVAL REQUEST

State Form 51311 (R / 10-04) / BCD 0088
Family and Social Services Administration



County		Date (month, day, year)	
Name of child		Date of birth (month, day, year)	
Name of Service Coordinator	Phone number of Service Coordinator ()	Fax number of Service Coordinator ()	
PRIOR APPROVAL IS REQUESTED FOR THE FOLLOWING SERVICE			
<input type="checkbox"/> Assistive technology (<i>list the piece of equipment with the HCPC code and two written quotes from the vendor</i>)			
Equipment		HCPC code	
Quote #1		Quote #2	
<input type="checkbox"/> Medical services (<i>for diagnostic purposes only</i>)			
<input type="checkbox"/> Transportation (<i>only for aides, meals, etc.</i>)			
<input type="checkbox"/> Other early intervention service (<i>please list the service requested and the cost</i>):			
Name of Service		Cost	
Name of Provider		Is the Provider currently enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Two therapists of the same discipline:			
Name of therapist #1		Name of therapist #2	
<input type="checkbox"/> Other (<i>Please Specify</i>): _____			
THE FOLLOWING INFORMATION MUST BE ATTACHED FOR ALL REQUESTS			
<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Eligibility documentation</div><div><input type="checkbox"/> Submission of documentation of team discussion</div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> The related outcome</div><div><input type="checkbox"/> Documentation of cost / bids from the vendor</div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Transition plan for equipment - If applicable (<i>Please attach the plan signed by the parent, provider and Service Coordinator</i>)</div><div><input type="checkbox"/> Written recommendation from the acting therapist</div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Prescription from the child's primary care physician</div><div></div></div>			
Please verify that the following activities have been completed			
<div style="display: flex; justify-content: space-between;"><div>Financial Case Management</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No</div></div> <div style="display: flex; justify-content: space-between;"><div>Child is eligible for Hoosier Healthwise</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No</div></div> <div style="display: flex; justify-content: space-between;"><div>Child is eligible for CSHCS</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No</div></div> <div style="display: flex; justify-content: space-between;"><div>Information has been submitted to CSHCS Care Coordinator</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</div></div>			
FOR ASSISTIVE TECHNOLOGY			
<input type="checkbox"/> List other equipment purchased/utilized below:			
THIS BOX IS FOR STATE PERSONNEL USE ONLY			
<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Approval <input type="checkbox"/> Denial <input type="checkbox"/> Pending info needed: _____</div><div></div></div> <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Check box if equipment will remain property of the State of Indiana, and notify Cluster SPOE once equipment has been returned.</div><div></div></div>			
Reason for denial			
Signature		Date (month, day, year)	